STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155705	A. BUILDING 00 B. WING	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE POINTE	801 N HUNTINGTON AVENUE WARREN, IN46792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification, State Licensure, and State Residential Survey. Survey dates : May 9, 10, 11, and 12, 2011 Facility number : 000542 Provider number : 155705 AIM number : 100267380 Survey team: Kim Davis, RN, TC Vicki Bickel, RN Donna Smith, RN Tammy Alley, RN Toni Maley, BSW DeAnn Mankle, RN (5/10, 5/11, and 5/12, 2011) Census bed type: SNF : 14 NF : 54 SNF/NF : 68 Residential : 167 Total : 303 Medicare : 14 Medicaid : 63 Other : 226 Total : 303 Sample : 24	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Supplemental Sample : 9 Residential Sample : 7 These deficiencies cited also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 5-17-11 Cathy Emswiller RN			
F0167 SS=C	A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to have the results of the most recent survey readily available for the residents for their review as indicated by 12 of 12 residents that attended the group meeting (# 3, 22, 26, 60, 67, 85, 117, 120, 121, 128, and 134) and for 2 of 2 survey books observed. This practice had the potential to impact 137 residents . Findings include: 1. During the environmental tour on 5/11/2011 at 9:40 A.M., with the housekeeping supervisor, the front lobby of the building was observed for the survey book. The receptionist was	F0167	Please note that there were a total of 6 survey books available in the facility with a sign posted at the entrance stating the location of each book. All residents have been identified as being affected should they desire to review survey findings. In addition, the survey book at the reception desk was in fact complete and all books are always updated at the same time. It is likely that someone pulled the complaint survey dated 9/10/10 from the book in the library. The book in the library was updated again on 5/11/11 and all other survey books were checked to ensure they were up-to-date as well. All survey books were checked to ensure they were complete and	05/12/2011

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	interviewed about the location of the survey book. She indicated the survey book was on the desk behind the her in her office. On 5/11/2011 at 11:45 A.M.,with the housekeeping supervisor, a second loose leave notebook with the survey results was observed on the bottom shelf of the newspaper rack in the library. The contents of this survey book's last survey posted in the book had a date of 06/04/2010. A complaint survey had been completed on 09/10/2010, but the results were not posted in the survey book. There was no sign posted that indicated the location of the survey book. During the group meeting on 05/10/2011 at 10:45 A.M., Residents #3, #22, #26, #60, #67, #85, #117, #120, #121, #127, #128, and #134 indicated they did not know where the results of the last survey where located in the building. During an interview with the social worker #6 on 5/12/11 at 9:30 a.m., she indicated the facility had placed the survey results in the books last night and they were available for the residents. 3.1-3(b)(1)		were relocated so that they will be accessible to residents without having to ask staff for them. New signs were posted as to where the location of the survey results can be found. All survey books will be reviewed monthly for 3 months then quarterly to ensure they are up-to-date. Replacements will be put in any books found to have missing survey results. Any concerns will be reported to the QA Committee for review and recommendations.	

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F0248 SS=E	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to provide weekend activities to meet individual resident needs and desires for 3 of 13 residents interviewed in a group setting. (Resident # 79, # 26, and # 22) and for 4 of 4 cognitively impaired residents review for activity participation in a sample of 24 (Resident # 12, # 94, # 59, and 89) and had the potential to affect 16 of 16 cognitively impaired residents and the potential to affect all residents who were unable to self initiate activities. Findings include: 1. A list of interviewable residents was provided on 5/10/11 at 10:10 a.m. by Social Worker # 6. Resident # 79, # 26 and # 22 were on the list. During a group interview on 5/10/11 at 10:45 a.m., Resident # 26 indicated there was "not much to do on the weekends." She indicated there was bingo on	F0248	All healthcare residents on 2A, 2B, and 1A were identified to be potentially affected. The 1B Healthcare Unit is a Dementia Unit with specialized activities 7 days per week. Activities such as current events, music and trivia will be incorporated at meal time and added to the weekend activity calendar. Residents #79, #26, #22 and other alert and oriented residents were given a survey of potential activities they would enjoy on weekends. These suggestions will be incorporated into the weekend programming. The Activity staff will be required to work more hours on weekends which will include activities for alert and oriented residents as well as residents with dementia that cannot speak for themselves. Interviews will be done with a minimum of 3 residents on 1A, 2A and 2B weekly for 4 weeks then monthly for 2 months then quarterly to ensure residents are receiving on-going activity programming designed to meet their interests	06/01/2011

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	Saturdays. She indicated she wanted more to do but she had not talked to anyone about this. Resident # 22 and # 79 also indicated there was nothing to do on the weekends but church and bingo. The April and May 2011 activity calendar was reviewed on 5/10/11 at 1 p.m. The calendar schedule for the weekend was a follows for all the Saturday and Sundays except for May 7, 2011 when there was a Mother's Day party. Saturdays: 12 p.m.: Daily Chronicles 2 p.m.: Movie Channel 63 2 p.m.: Bingo 8 p.m.: Gaither Gospel Hour Channel 47 Sundays: 9:30 a.m.: Church 12 p.m.: Daily Chronicles 2 p.m.: Movie Channel 63 During the week Monday -Friday, there were 4 to 6 activities scheduled daily, including but not limited to, sensory club, art expression, sing along, sit and stretch, sewing club, cooking, bible study, comfort touch, games galore, card club, pretty nails, exercise and name that tune. Review of the activity employee staffing hours as worked on 5/11/11 at 9 a.m.,		and physical, mental and psychosocial well-being. Any activity concerns will be reported to the QA Committee for review and recommendations.	

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	indicated that one activity employee worked on Saturday for approximately 2 hours and no activity employee worked on Sundays. During interview on 5/11/11 at 10 a.m., activity worker # 8 indicated he did not work on Sundays. He indicated Daily Chronicles was a facility newspaper that was given out in the dining room. He indicated the Sunday movie was on Channel 63 in the resident's room and the staff would have to turn the TV on for resident's who could not self initiate. He indicated there was no activities led by staff on Sundays. During an interview with CNA # 9 on 5/11/11 at 10:10 a.m., she indicated she works every other weekend. She indicated there were no scheduled events on the weekend except bingo on Saturday. She indicated there were volunteers and family visitors. During an interview with CNA # 11 on 5/11/11 at 10:30 a.m., she indicated she worked on the weekends. She indicated there were not activities for the residents to attend like through the week. She indicated there was church on Sunday. She indicated it is very busy through the week with activities and just not that busy on the weekends.			

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2. The record for Resident # 12 was reviewed on 5/11/11 at 9:30 a.m.

Current diagnoses included, but were not limited to, dementia.

A 3/2/11 activity assessment indicated the resident was involved in the following activities: music, hobbies, reading, spiritual, walking/wheeling outdoors, watching TV, movies, talking/conversing, and visits. The assessment indicated the resident preferred activities in her room, day/activity room and off the unit and enjoyed single or group settings.

Resident # 12's activity attendance record provided by social worker # 6 on 5/11/11 at 3 p.m.,for April and May 2011, indicated the resident attended 1 to 4 activity events daily Monday-Friday which included, but were not limited to, sensory club, sing along, sit and stretch, here's the news, art club, relaxation station, chapel, name that tune, comfort touch, fine art program, pretty nails, and movie. The attendance records indicated the resident did not attend any of the weekend events except the Mother's Day party on May 7, 2011.

3. Resident #94's record was reviewed on 5/9/11 at 2:45 p.m. The resident diagnoses included, but were not limited

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to, dementia and depression.

The "Resident Activity Assessment," dated 4/22/11, indicated the resident was awake during the morning and evening. She preferred activities in her own room and inside the nursing unit/off unit. Her average time in activities was from 1/3 to 2/3 of the time. The preferred group size was a small or large group. The resident's current activities were music and watching television.

The resident's activity calendars indicated the following:

In April, 2011, the resident attended 1 activity on 4/11, 12, 13, 18, 19, 21, 25, and 26. The resident attended 2 activities on 4/6, 7, 14, and 28. No attendance on the weekends were indicated.

In May 1 to 10, 2011, the resident attended 1 activity on 5/2, 3, 4, and 10 and attended 2 activities on 5/5. No attendance on the weekend were indicated.

On 5/12/11 at 11:10 a.m. during an interview, Social Worker #6 indicated the resident did not have 1 to 1 visits due to she was able to participate in activities.

4. Resident #59's record was reviewed on

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	5/9/11 at 11:05 a.m. The resident's diagnoses included, but were not limited to, dementia and depression. The "Resident Activity Assessment," dated 3/17/11, indicated the resident was awake in the morning. She preferred activities in the day/activity room. Her average time in activities was 1/3 to 2/3 of the time. The preferred group size was a small and large group. The resident's current activities were music, radio, walking/wheel outdoors, watching television, movies, talking/conversing, and resident visits. The resident's activity calendars indicated the following: In April, 2011, the resident attended 1 activity on 4/11, 14, 19, 21, and 26. The resident attended 2 activities on 4/7, 13, 25, and 28. She did refuse an activity on 4/5 and 4/12. No attendance on the weekends were indicated. In May, 1 to 10, 2011, the resident attended 1 activity on 5/2 and 5/3 and attended 2 activities on 5/5. No attendance on the weekend were indicated. On 5/12/11 at 12:30 p.m. during an interview, Social Worker #6 indicated the			

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	resident did not have 1 to 1 visits due to she was able to participate in activities. 5. Resident #89's record was reviewed on 5/11/11. The resident's diagnoses included, but were not limited to, dementia and depression. The "Resident Activity Assessment," dated 4/15/11, indicated the resident was awake in the morning. She preferred activities in her own room and in the day/activity room. Her average time in activities was 1/3 to 2/3 of the time. The preferred group size was a small and large group. The resident's current activities were music, spiritual/religious activities, and watching television. The resident's activity calendars indicated the following: In April, 2011, the resident attended 1 activity on 4/5, 14, 18, 19, 25, and 29. The resident attended 2 activities on 4/28. She did refuse an activity on 4/4, 7, 11, 12, 18, 21, and 26. A CNA did a manicure for the resident on 4/15. No attendance on the weekends were indicated. In May, 1 to 10, 2011, the resident refused an activity on 5/2, 3, 5, and 9. No further attendance was indicated on the calendar,			

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	including on the weekends. 3.1-33(c)			

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F0278 SS=D	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, interview, and record review, the facility failed to ensure a Minimum Data Set Assessment (MDS) was accurate related to a resident's vision for 1 of 24 sampled residents (# 115). Findings Include: Resident # 115 was interviewed on 5/9/11 at 1:30 p.m. The resident indicated she could only see shadows. She could not	F0278	All residents with highly impaired vision were identified by reviewing with the Charge Nurse on each unit to determine if other residents were affected by this practice. Chart reviews were done on all residents with highly impaired vision to identify any potential problems with their MDS and care plans. MDS Coordinators will compare new MDS's with the previous MDS's and review diagnoses to ensure MDS's are accurately done to reflect vision impairment. QA	05/27/2011

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	see well enough to complete her weekly menu. The resident indicated her family or staff assisted her to make out her meal choices. The clinical record of Resident # 115 was reviewed on 5/11/11 at 8:00 a.m. The Resident's diagnoses included, but were not limited to, heart disease, Hypothyroidism, and Diabetes. The Quarterly MDS dated 1/18/11 indicated the resident's vision was "highly impaired". The Significant Change MDS dated 3/8/11 indicated the resident's vision was "adequate". The Care Area Assessment (CAA) Summary dated 3/8/11 did not trigger a vision concern. The only care plan related to vision was the Activity care plan dated 3/8/11. The MDS nurse was interviewed on 5/11/11 at 1:00 p.m. The nurse indicated the 3/8/11 MDS was not accurate. 3.1-31(c)(4)		audits will be completed on MDS' s as they are due for the next 2 months then quarterly to ensure the MDS accurately reflects resident diagnoses. Any problems or concerns will be reported to the QA Committee for review and recommendations.	

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to ensure a care plan related to a resident's vision was in place for 1 of 24 residents care plans reviewed in a sample of 24 sampled residents (# 115). Findings Include: Resident # 115 was interviewed on 5/9/11 at 1:30 p.m. The resident indicated she could only see shadows. She could not	F0279	All residents with highly impaired vision were identified by reviewing with the Charge Nurse on each unit to determine if other residents were affected by this practice. Chart reviews were done on all residents with highly impaired vision to identify any potential problems with their MDS and care plans. A new care plan was written for Resident #115. MDS Coordinators will compare new MDS's with last MDS's to ensure MDS's, CAA's and care plans are accurately done to reflect vision impairment. QA audits will be completed on all residents with highly impaired vision. They will have their care	05/27/2011

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	see well enough to complete her weekly menu. The resident indicated her family or staff assisted her to make out her meal choices. The clinical record of Resident # 115 was reviewed on 5/11/11 at 8:00 a.m. The Resident's diagnoses included, but were not limited to, heart disease, hypothyroidism, and diabetes. The Quarterly MDS dated 1/18/11 indicated the resident's vision was "highly impaired". The Significant Change MDS dated 3/8/11 indicated the resident's vision was "adequate". The Care Area Assessment (CAA) Summary dated 3/8/11 did not trigger a vision concern. The only care plan related to vision was the Activity care plan. The MDS nurse was interviewed on 5/11/11 at 1:00 p.m. The nurse indicated the 3/8/11 MDS was not accurate and a vision care plan was not in place. 3.1-35(a)		plans reviewed monthly for 3 months then quarterly to ensure care plans accurately reflect each resident's vision status. Any problems or concerns will be reported to the QA Committee for review and recommendations.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure a physician order for a three compartment plate was followed during 3 of 4 meal observations for 1 of 24 residents reviewed for eating in a sample of 24 (# 114). Findings include: The clinical record of Resident # 114 was reviewed on 5/9/11 at 10:15 a.m. The record indicated the resident's diagnoses included, but were not limited to, Esophageal Reflux, Anemia, and Dementia. The current physician orders signed on 5/3/11 included an order dated 4/28/11 for a divider plate. A dietician note dated 4/28/11 indicated, "... new order for divider plate...".	F0282	The employee responsible for this action received a written warning for neglecting job responsibilities. All residents with orders for adaptive equipment at meal time were reviewed and checked to ensure the orders are being followed. An in-service on Tray Cards and the Importance of Table Setting Accuracy will be given to all Dietary employees on May 25, 2011. A location on the tray card was added for a divided dish. It appears under meal service and it now also appears with the diet order on the tray card. QA checks will be performed by the Dietary Manager, Assistant Dietary Manager and Shift Supervisors 3 times a week for 2 weeks at all meals then monthly for 3 months then quarterly. Any concerns will be reported to the QA Committee for review and recommendations.	05/25/2011

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	155705	A. BUILDING 00 B. WING	05/12/2011

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	The noon meal was observed on 5/9/11 between 12:00 p.m. and 1:00 p.m. Resident # 114 was served his food on a regular plate at 12:10 p.m. The breakfast meal was observed on 5/10/11 between 8:10 a.m. and 8:30 a.m. Resident # 114 was served biscuits and gravy on a regular plate and hot cereal in a bowl. The breakfast meal was again observed on 5/11/11 between 8:00 a.m. and 8:30 a.m. Resident # 114 was observed eating his breakfast on a regular plate. Cook # 16 was interviewed on 5/11/11 at 10:00 a.m. The cook indicated Resident # 114 needed a three compartment divider plate because he had difficulty scooping his food from a regular plate. The cook indicated she knew about the order, but forgot to use the divider plate. 3.1-35(b)(1)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observations, record reviews, and interviews, the facility failed to ensure infection control practices were followed in a manner to prevent the potential for the spread of infections and	F0441	All laundry carts throughout the facility were observed during linen pass to ensure the carts were properly covered during linen pass. All Laundry employees attended an in-service on Delivery	06/06/2011

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	diseases concerning linen handling for 2 of 2 laundry staff observed (Laundry aide #1 and Laundry aide #2) passing personal linen in 2 of 2 hallways (1A and 2A) for 4 of 5 linen handling observations, and concerning handwashing and glove use for 6 of 7 nursing staff observed (CNA #'s 3, 4, 5, 7, 13, and 14) during personal care and/or Hoyer transfers. This deficiency had the potential to impact 101 of 136 residents, who were designated as incontinent, and to impact 30 of 136 residents, who utilize the Hoyer lift. (Resident #'s 93, 94, 59, and 60) Findings include: 1. The "DELIVERY OF RESIDENT'S PERSONAL CLOTHES AND LINEN" policy was provided by the Housekeeping Supervisor. This current policy indicated the following: "HEALTH CARE UNIT 1.) Bring both the folding and hanging items to the units on the appropriate delivery carts. The delivery carts will be covered. 2.) Uncover one side at a time as the items are removed from the cart....." 2. On 5/9/11 at 12:31 p.m., Laundry Aide #1 was observed to be passing personal		of Residents Clothing and Linen for both Residential and Healthcare on 5/23/11. The importance of following the policy and infection control was reviewed. Failure to follow protocol will result in disciplinary action. If a problem should occur, then it must be brought to the attention of either the Laundry Supervisor or the Environmental Services Director. Signs have been posted in Laundry reminding staff to ensure linens are covered and infection control policies are followed. The Laundry Supervisor will review the delivery procedure weekly for 4 weeks both in Residential and Healthcare then quarterly. Any concerns will be reported to the Infection Control Committee and the QA Committee for review and recommendations.Health Care Unit; Page 17, Item 5:CNA #3 is a student nursing assistant (SNA). She was immediately pulled off the floor and retrained. All other SNAs were retrained prior to providing direct care to residents. Infections of potential residents will continue to be monitored per facility infection control program. As corrective action for Resident #94, CNA #7 was in-serviced on hand washing and pericare with return demonstration of skills to ensure knowledge of proper care. CNA #7 was given a formal write-up. CNA #7 reviewed hand washing and perineal care policies with the	

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	clothing down the 2A hallway. The cart was left uncovered as Laundry Aide #1 continue to enter and exit several of the resident's rooms. During this same observation and upon entering the opposite side of the 2A hallway, Laundry Aide #2 was also observed passing personal hanging clothes from room to room with each end of the cart cover tied to the sides of the cart. On 5/9/11 at 12:43 p.m. during an interview, Laundry Aide #2 indicated she tied the cart cover to the ends of the cart due to the cover would get caught in the cart's wheels and would slip off of the cart. On 5/9/11 at 1:05 p.m., Laundry Aide #2 was observed to continue to pass the resident's personal hanging clothes from room to room with the linen cart uncovered and the cover ends remained tied to the ends of the cart. 3. On 5/10/11 at 10:10 a.m., Laundry Aide #1 was observed to be passing resident's personal clothing down the 2A hallway with the cart uncovered. The cover of the cart had its ends tied to the end of the cart leaving the resident's personal clothing uncovered. 4. On 5/10/11 at 10:10 a.m. at 12:50 p.m., Laundry Aide #1 was observed to be passing resident's personal clothing down		DON. As corrective action for Resident #59, CNA #3, CNA #4, CNA #13, and CNA #14 were in-serviced on hand washing and pericare with return demonstration of skills to ensure knowledge of proper care. CNA #3, CNA #4, CNA #13 and CNA #14 were also given a formal write-up. They reviewed hand washing and perineal care policies with the DON. Please noted that Resident #60 is not transferred by hoyer lift or have a catheter. CNA #5 was in-serviced on hand washing and pericare with return demonstration of skills to ensure knowledge of proper care. CNA #5 was given a formal write-up. CNA #5 reviewed hand washing, daily catheter care and perineal care policies with the DON. The hand washing and sanitizing policy was reviewed. Use of gloves, standard precautions, perineal care and daily catheter care policies were updated. All staff were in-serviced on hand washing and pericare with return demonstration of skills to ensure knowledge of proper care and to prevent reoccurrence. Hand washing in-services will be conducted monthly for 3 months with the annual in-service due in June 2011 and then semi-annual. QA audits will be done monthly for 3 months and then quarterly. These audits will be conducted by watching CNAs provide care. Staff not following proper hand	

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	the 1A hallway with the cart uncovered. The cover of the cart had its ends tied to the end of the cart leaving the resident's personal clothing uncovered. 5. The "USE OF GLOVES, STANDARD PRECAUTIONS" policy was provided by the ADON #12 on 5/10/11 at 2:00 p.m. This current policy indicated the following: "...PROCEDURE ...3. When moving from one surface or contamination level to another (washing resident, to oral care, perineal care to routine care of resident) you MUST removed contaminated gloves, wash hands, and put on clean gloves, as needed for the next task. 4. ALWAYS remove gloves, and wash hands between contact with each resident. ...8. ALWAYS thoroughly wash hands after removing gloves....." The "HANDWASHING AND SANITIZING" policy was provided by the ADON #12 on 5/10/11 at 2:00 p.m. This current policy indicated the following: "...Handwashing/sanitizing will be practiced as follows: ...2. Before and after resident contact 3. After contact with source of microorganisms (body fluids, mucous		washing or pericare procedures will result in disciplinary action. Any problems or concerns will be reported to the QA Committee for further review and recommendations.	

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	membranes, non-intact skin, or items that are likely to be contaminated.) 4. Between tasks and procedures on the same resident to prevent cross-contamination of different body sites ...Hands must be washed after removing disposable gloves. The gloves may have an unseen hole, and gloves may be removed incorrectly, contaminating the hands....." 6. On 5/9/11 from 11:40 a.m. to 12:10 p.m., Resident #94's transfer was observed. After the Hoyer lift transfer was completed, CNA #7 removed the Hoyer lift from Resident' #94's room and proceeded down the hallway entering Resident #93's room as she was observed to prepare her for her Hoyer lift transfer. No handwashing or handgel use was observed. 7. On 5/09/11 from 12:15 p.m. to 12:30 p.m., Resident #59's personal care was observed. CNA #3 indicated the resident had been incontinent of urine. After CNA #3 and CNA #4 donned a pair of gloves, the resident's brief was partially removed as the resident's front peri-area care was performed. Next, CNA #3 and CNA #4 turned the resident, and as the resident's brief was removed, the resident had been incontinent of a large amount of loosely			

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	formed bowel movement (BM). During the rectal cleaning of BM, BM was observed on CNA #3's gloved hands as she indicated she was "getting it all over me" and may need to "change places or gloves." With the same gloves CNA #3 completed the resident's rectal care. After the resident's brief was in place and secured, CNA #3 and CNA #4 removed their gloves. No handwashing or handgel use was observed. Next, CNA #3 and CNA #4 continued to turn the resident back and forth in bed while pulling her pants up and positioning the Hoyer sling under her in preparation for her transfer. CNA #4 donned a new pair of gloves and bagged the soiled wipes and brief and removed her gloves. No handwashing or handgel use was observed. After the Hoyer sling was hooked to the Hoyer lift, CNA #3 positioned the resident's right hand across her chest as CNA #4 operated the Hoyer lift, and the resident was transferred to her chair. After the Hoyer sling was unhooked from the Hoyer lift, CNA #4 and CNA #3 both handwashed. CNA #3 then combed the resident's hair and took her out to the dining room. No handwashing or handgel use was observed as CNA #4 removed the bagged trash and exited to the soiled utility room. 8. On 5/9/11 at 5:05 p.m., Resident #59's Hoyer lift transfer was observed. With			

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	ungloved hands CNA #13 and CNA #14 transferred the resident from her bed to her chair. After the transfer was completed, CNA #14 was observed to leave the room with the Hoyer lift as CNA #13 placed the resident's alarm on her and transported her in her chair to the dining room. No handwashing or handgel use was observed before exiting the room after completing the Hoyer lift transfer. 9. On 5/12/11 at 8:35 a.m. during an interview, ADON #12 indicated when one's tasks were completed, one should handwash before leaving the room. 10. The "RESIDENT CENSUS AND CONDITIONS OF RESIDENTS" was provided by the Administrator on 5/9/11 at 10:30 a.m. One hundred and one residents were identified as occasionally or frequently incontinent of bladder. The list of residents, who utilized the Hoyer lift, was provided by the ADON #17 on 5/12/11 at 10:15 a.m. Thirty residents were identified on this current list. 6. The clinical record of Resident #60 was reviewed on 5/9/11 at 3:40 p.m. Diagnosis included but were not limited to: cerebral vascular accident, hemiplegia, dysphagia, atrial-ventricular block, pacemaker, esophageal reflux, depression, anxiety and			

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	urinary tract infection. Resident # 60 was observed on 5/10/11 at 1:35 p.m. for pericare, without a previous incontinent episode, with CNA #5. The resident was transferred by hoyer lift, with 2 CNA's assisting, to the resident's bed. The resident was positioned for pericare with slacks and brief removed. CNA #5 washed her hands and donned clean gloves. A clean, moistened towelette was used to clean between the labia, the labia, and the groin area. The soiled towelette was then disposed of in the garbage container. The catheter tubing was also cleaned with a second, clean, moistened towelette and disposed of in the garbage container. The CNA did not remove her soiled gloves after cleansing the peri-area. With the same soiled gloves on, the CNA obtained the moisture barrier cream from the resident's night stand and applied it between the labia, labia and groin of the resident. During an interview on 5/10/11 at 2:00 p.m., with Assistant Director of Nursing #12, indicated the CNA should have changed gloves after cleansing the peri-area and prior to obtaining the moisture barrier cream. 3.1-18(l) 3.1-19(g)			

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R0042	(p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to have the results of the most recent survey readily available for the residents for their review for 2 of 2 survey books observed. This practice had the potential to impact all residents. Findings include: 1. During the environmental tour on 5/11/2011 at 9:40 A.M., with the housekeeping supervisor, the front lobby of the building was observed for the survey book. The receptionist was interviewed about the location of the survey book. The receptionist indicated the survey book was on the desk behind the her in her office. On /11/2011 at 11:45 A.M.,with the housekeeping supervisor, a second loose leave notebook with the survey results was observed on the bottom shelf of the newspaper rack in the library. The contents of this survey book's last survey posted in the book had a date of	R0042	Please note that there were a total of 6 survey books available in the facility with a sign posted at the entrance stating the location of each book. All residents have been identified as being affected should they desire to review survey findings. In addition, the survey book at the reception desk was in fact complete and all books are always updated at the same time. It is likely that someone pulled the complaint survey dated 9/10/10 from the book in the library. The book in the library was updated again on 5/11/11 and all other survey books were checked to ensure they were up-to-date as well. All survey books were checked to ensure they were complete and were relocated so that they will be accessible to residents without having to ask staff for them. New signs were posted as to where the location of the survey results can be found. All survey books will be reviewed monthly for 3 months then quarterly to ensure they are up-to-date. Replacements will be put in any books found to have missing survey results. Any concerns will	05/12/2011

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	06/04/2010. A complaint survey had been completed on 09/10/2010, but the results were not posted in the survey book. There was no sign posted that indicated where the survey book could be found. During an interview with the social worker #6, she indicated the facility had placed the survey results in the books last night and they were available for the residents.		be reported to the QA Committee for review and recommendations.	
R0154	(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review the facility failed to maintain a sanitary ice machine potentially affecting 20 of 20 residents utilizing that ice machine that reside on the 3rd floor assisted living area. Findings include: The tour of the satellite kitchenette, located on the 3rd floor assisted living unit, was conducted on 5/10/11 at 8:10 a.m., with Certified Dietary Manager of the Kitchen	R0154	All ice machines in the facility were inspected to ensure they were clean, free from litter, rubbish and that they were in good repair. The ice machine located on the third floor assisted living unit was immediately cleaned. All other ice machines in the facility were clean and in good repair. Dietary staff have been in-serviced on the policy for cleaning the ice machines. A Monthly Cleaning Schedule to clean the ice machines, scoops	06/01/2011

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	#15. The ice machine located on this unit was inspected with the CDM present. The ice machine fold up lid was lifted. The inside ice making apparatus, located just above the ice cubes, was observed to have a rust colored substance on it. A clean paper towel was used to wipe the substance from the ice-making apparatus. The substance came off on the paper towel. The substance was slimy and rust colored. The CDM indicated during an interview on 5/10/11 at 8:40 a.m. that the ice machine had recently been worked on and evidently was not cleaned after the repairs were completed. The facility policy received and reviewed on 5/11/11 indicated " equipment and utensil cleanliness and sanitation.... #20. ice machines shall be delimed in accordance with manufacturer's recommendations and water line content by the maintenance department".		and trays on a monthly basis has been adopted for the Dietary employees to follow. The Dietary Manager, Assistant Dietary Manager and Shift Supervisors will ensure compliance through QA checks bi-monthly for 2 months and then quarterly. Any concerns will be reported to the QA Committee for review and recommendations.	